Chapter II

Socio-Economic and Cultural Dimensions of Health

The socio-economic and cultural conditions of a society provide the context against which we can examine the issues related to health and illness. I have given an overview of the socio-economic background of the people under study in the last chapter. In this chapter I have examined the influence of socio-economic and cultural factors on health and illness in the study area.

Socio–economic and cultural factors have a substantial influence on health. Similarly, the treatment of illnesses is also affected largely by socio-economic factors. The economic background of the family or the community, the level of education, exposure to the outside world, and knowledge of modern methods of medicinal practices can largely influence peoples' idea of good life, sanitary conditions in and around the house, health habits and approach to illness. The educated and relatively advanced section in a community, which takes a strong stand in favour of modern methods of treatment, can also influence the health perception and health behaviour of the other sections of people in society.

Socio-economic status also has a role in shaping perceptions towards health. While in general, the rich tend to be far-sighted and have the resources to go for modern methods, the economically deprived, on the other hand, are unable to go for the desired change due to lack of financial support. When people are economically well-off they are in a better position to acquire the education/ skills necessary, gain exposure to innovations and find opportunities to live a healthy life as they understand it. These are however general observations at the hypothetical plane and the reality might differ or conform to these hypothetical observations.

In any social context there is always a burden of traditional modes of perceiving health and illness, which are collectively shared and practiced. Such complex of beliefs and perceptions, however, are never stationary; they always undergo stresses and strains from the forces of modernity, the exogenous forces. A change in the objective conditions of life (or the social reality) is bound to have its repercussions on health perceptions and health behaviour, which could in brief be termed health culture. When we are young we learn the traditional way of life specific to our society. These traditions are deeply ingrained in us and sometimes even education fails to annihilate them completely. An example of this is the strong religious belief in God and fate that even highly educated hold on to. Religion is part and parcel of Nepali society, presumably more so in rural areas such as Banigama, particularly among the

female population. These religious beliefs entice women to resort to fasting when they have health problems, wish for a son, a good husband, alleviate family money problems or tame a missing/philandering husband or son etc. They also organise various religious programs like "Shaptah", "Nawhaa" and other rituals in order to establish peace in their households.

Cultural norms and taboos also have a direct influence on health. Brahmin/Chhetris traditionally do not drink alcohol, which might unknowingly contribute to healthy living; in contrast, alcohol is an ingrained part of Tharu and Newar cultures, resulting in higher incidences of liver problems and tuberculosis. Traditional dependence on faith healers is another indicator of the health awareness of any community.

Agricultural land and income that define the class character of the people are also seen to affect the illness and health behaviour greatly. Those with high incomes have the means to take the sick person to a doctor although the option of depending on faith healers and local quacks is always open. Moreover, the habit of frequent trips to health-posts means that they are less likely to fall prey to unexpected health problems.

Khaini Culture

Smoking and chewing tobacco was noticeably a common habit among Banigama dwellers, especially males. The tobacco powder is mixed with lime (popularly known as 'Khaini' in local parlance) inside their lower lip. Tobacco chewing has over time become a culturally accepted behaviour; the multiple repercussions this might have caused to the users' health are now becoming apparent.

Khaini (tobacco) culture is quite common in the study area and taken by both the young and the adult equally. Khaini can be made locally without any difficulty and is often replaced in cigarettes. Even boys as young as 10-11 learn to use khaini from their peer groups.

Field observation indicates that since it is socially acceptable, the residents of Banigama village are not conscious of the side effects of Khaini. It was noted that even young boys use Khaini in front of their parents without any hesitation. Persistent use of Khaini has a kind of slow poison effect and does not show immediate reaction. Khaini addicts can develop ulcers and even oral and lung cancers that can be fatal. Excess nicotine in Khaini hampers the brain directly and precipitates cancer, too. When used in excess, Khaini can cause skin drying and loss of appetite, leading to weakness and fatigue.

The Khaini culture in Banigama blurs one of the traditional caste principles, namely untouchability, followed in a caste divided society like Nepal. While higher castes like

Brahmin/Chhetris do not drink or eat things touched by lower castes such as Damai, Kami, Sarki and Chamar, Khaini is exempted from this rule as anyone can pass/take Khaini from anybody's hand. There is no constraint of untouchability or class bar in acceptance of Khaini. The Khaini culture is functional in that it succeeds in bringing people belonging to various castes and classes closer.

Not only is Khaini a hazardous causative agent of many illnesses such as ulcers and cancers, it also harbours harmful bacteria. The preparation of Khaini is very unhygienic as production workers do not wash their hands while preparing Khaini.

Surti Culture

Banigama inhabitants have numerous unhealthy traditions which unconsciously invite various kinds of health hazards. Like Khaini, Surti is also very popular. Surti is another kind of tobacco with narcotic effect. Dry tobacco leaves are made into small pieces and placed inside the cheek, either directly or mixed with lime. Regular addicts use lime but occasional users appear to prefer plain Surti without lime. The widespread use of Surti in Banigama is suggestive of the fact that the locals are not aware of its negative impact. At the least, use of Surti causes body odour; the health hazards are multiplied if used with 'lime'. Excessive use with lime has been known to cause cancer.

Case Study

Case study is a tool especially suitable for underdeveloped countries such as Nepal where varied social institutions interact mutually. It is traditionally a method of qualitative analysis of a particular unit and is a major component of this research. The following case studies highlight the status of the Banigama inhabitants in terms of their socio-economic condition and the influence on health behaviour; as well as the influence of culture on health and illness.

The case studies below shows the bad effects of *'Khaini'* and *'Surti'* culture among Banigama dwellers.

Case-Study No. 1 (Household no. 7)

Mr. Basant Karki of Ward no. 1 aged 38 years, is a Chhetri by caste. He is a Parbatiya. He has completed his school level education. There are five household members in his house. He owns 7 bigha (4.66 ha.) of agricultural land. He has a house in Biratnagar headquarters also. He was happily enjoying his life with his family. Recently, he has developed a stomach

problem. When blood started coming from his stool, he went for the check-up in Biratnagar. He was advised by the doctor, to be admitted in hospital. He was diagnosed as ulcer patient. Doctor told him that he has developed blind ulcer. When this researcher started asking about his food habit and other associated factors; immediately Mr. Karki started repenting on his habit/addiction of *'Khaini'* and *'Surti'* taking. He said, "I started taking *'Khaini'* and *'Surti'* from the age of around 11-12 years. My present health problem is due to my bad habit.

Case-Study No. 2 (household No. 43)

Mr. Dinesh Yadav of ward no. 2 aged 52 years, is a Terai dweller. He is a literate Madhesia. Only one bigha (0.66ha.) of land is under his possession. He has rented-in 3 bigha (2 ha.) land on sharing. He has to support a large (8 members) family. Since last year he became frequently sick. After consulting '*Dhami*' (faith healer) several times, he went to the health-post for medication. But Mr. Yadav complains that his problem of severe stomach pain has not decreased. Instead, it is increasing day by day. Researcher asked whether he is habituated of *'Khaini'* and *'Surti'* culture? Mr. Yadav responded smilingly "Yes I take *'Khaini'* 8 to 10 times daily. Similarly, I take raw *'Surti'* (tobacco leaf) 4-5 times. He further elaborated of this habit he has developed since he was 13-14 years old. He is yet to be medically diagnosed because he did not go for second time check-up to the health center. Researcher found that the health problem which he has developed is due to *'Khaini'* and *'Surti'* intake. This harmful effect was seconded by the fact when Mr. Yadav says "a particular day when I do not take both *'Khaini'* and *'Surti'* I don't get pain in my stomach.". This researcher asked to Mr. Yadav, to stop taking both *'Khaini'* and *'Surti'*. Mr. Yadav says, "I will give a thought about it". Both cases above describes the harmful effects of *'Khaini'* and *'Surti'* in taking which affects the health of Banigama dwellers.

The table below documents various illnesses contracted by people in Banigama in the past six months.

Table 2.1: Illness reported in the past six months

Disease	Caste/ethnicity											
	Brahmin/ Chhetri		Tharu		Untouchable		Terai Dwellers		Others		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
HH Reporting	**22**	**81.48**	**100**	**87.72**	**10**	**76.92**	**20**	**90.91**	**2**	**100.00**	**154**	**86.52**
Measles	2	9.09	6	6.00	1	10.00	1	5.00	1	50.00	**11**	**7.14**
Cough	4	18.18	26	26.00	1	10.00	4	20.00		-	**35**	**22.73**
Worms	11	50.00	35	35.00	3	30.00	7	35.00	1	50.00	**57**	**37.01**
Fever	19	86.36	77	77.00	10	100.00	19	95.00	2	100.00	**127**	**82.47**
Respiratory problem	1	4.55	5	5.00		-	1	5.00	-	-	**7**	**4.55**
Diarrhea	4	18.18	27	27.00	6	60.00	4	20.00	1	50.00	**42**	**27.27**
Skin sores	2	9.09	11	11.00	1	10.00	3	15.00	-	-	**17**	**11.04**
Stomach aching	3	13.64	18	18.00	2	20.00	6	30.00	-	-	**29**	**18.83**
Headache	6	27.27	40	40.00	1	10.00	6	30.00	-	-	**53**	**34.42**
Total	**22**	**100.00**	**100**	**100.00**	**10**	**100.00**	**20**	**100.00**	**2**	**100.00**	**154**	**100.00**

Table 2.1 presents illness reported by households by caste and ethnicity in the past six months. Data indicate that fever and diarrhoea appear to be more common in Untouchable households than in other castes/ethnic groups of the study area.

Fever was reported to be the major health problem in other households (Newars and Tamang: Tibeto-Burman group) followed by equal incidences of measles, tapeworm and diarrhoea. The major illness in both the Brahmin/Chhetri and Tharu households was fever, followed by headaches and tapeworms.

The findings above suggest that the most common ailments in Banigama VDC were fever, worms, diarrhoea and headaches.

Table 2.2: Illness in past Six Months among the Income Groups

Disease	Income Level											
	5 to 10 thousand		10 to 15 thousand		15 to 20 thousand		20 to 25 thousand		> 25 thousand		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
HH Reporting	**83**	**87.37**	**23**	**82.14**	**21**	**84.00**	**16**	**94.12**	**11**	**84.62**	**154**	**86.52**
Measles	8	9.64	6	-	1	4.76	-	-	2	18.18	**11**	**7.14**
Cough	19	22.89	5	21.74	7	33.33	3	18.75	1	9.09	**35**	**22.73**
Worms	29	34.94	10	43.48	6	28.57	7	43.75	5	45.45	**57**	**37.01**
Fever	70	84.34	16	69.57	18	85.71	15	93.75	8	72.73	**127**	**82.47**
Respiratory problem	6	7.23	-	-	1	4.76	-	-	-	-	**7**	**4.55**
Diarrhea	20	24.10	7	30.43	4	19.05	9	56.25	2	18.18	**42**	**27.27**
Skin sores	11	13.25	2	8.70	2	9.05	1	6.25	1	9.09	**17**	**11.04**
Stomach aching	15	18.07		-	2	9.52	6	37.50	6	54.55	**29**	**18.83**
Headache	29	34.94	7	30.43	8	38.10	3	18.75	6	54.55	**53**	**34.42**
Total	**83**	**100.00**	**23**	**100.00**	**21**	**100.00**	**16**	**100.00**	**11**	**100.00**	**154**	**100.00**

Table 2.2 presents the incidence of diseases in the last six months in the households belonging to different income groups. Data reveal that there are many diseases which occur with greater frequency among the low-income group (NRs 5000-10000) households. From the same table, it is evident that the incidence of diseases and income levels are negatively correlated. In other words, more people in the low-income group got sick (87.37%) during the last six months. However, an overwhelming majority (94.12%) of the NRs. 20000-25000 income group also reported high degree of illness. This was largely was attributed to fever (15 out of 16 households). Likewise, with 8 out of 11 households in the NRs 25000 plus income group reported incidences of fever. Fever, therefore, appears to be the primary health problem in the study area followed by tapeworm and headache.

From the above table it is quite clear that the high-income population appear to have higher health awareness as they seek clean drinking water and have properly constructed latrines. The households with access to clean drinking water and better sanitation can avoid many of the water borne diseases. In contrast the low income population are not aware of factors influencing health and are plagued by various diseases as a consequence.

The following case study illustrates the influence of socio-economic conditions not only on the sick individual but also its impact on the whole family.

Case-Study No. 3 (Household no. 8)

Mr. Bishnu Lal Giri, of Ward no.1, Banigama is a 58 year old man. He owns 1.5 bigha (1 ha.) of agricultural land and has five members in his household. His three sons have completed high school (SLC) and have been searching for jobs over the last couple of years. Mr. Giri used to support the family by working as a driver. However, he has been unemployed for the past two years due to his illness.

Two years ago, he underwent a prostrate operation in Kathmandu. His ailments persisted after the operation and Mr. Giri has been compelled to periodically consult doctors in both Biratnagar (District headquarters 17 kms from Banigama) and in Kathmandu since then. He has been diagnosed as having cancer and his medication costs already amount to a staggering NRs. 250,000 which he accumulated by selling livestock, ornaments and half of his land. Understandably, all the family members are emotionally upset and financially distressed. Mr. Giri laments: "I feel hopeless. I might not be cured but my family will suffer because we have lost all our savings for my treatment." Visibly upset Mr. Giri said: "I must have sinned in my previous life to be suffering so much now." He was so depressed to have lost everything (money and job) and was so upset to see his family suffering that he appeared to have given up on life.

The case study shows the unfortunate chain of events triggered by Mr. Giri's illness. When his regular source of income ceased, he had to sell the live-stock. He couldn't afford further treatment and planned to die at his own dwelling. The savings pooled into his treatment also affected his family members directly.

The table below presents diseases in the last six months among the households in different land holding categories.

Table 2.3: Illness in the Last Six Months among the Agrarian Categories

Disease	Size of Land Holding													
	Landless		Below 0.50 ha		0.50-1.0 ha		1.0 to 3.0 ha		3.0 to 3.5.0 ha		Above 5.0 ha		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
HH Reporting	45	93.75	35	87.50	32	86.49	28	77.78	11	91.67	3	60.00	154	86.52
Measles	2	4.44	1	2.86	2	6.25	3	10.71	2	18.18	1	33.33	11	7.14
Cough	9	20.00	10	28.57	5	15.63	6	21.43	4	36.36	1	33.33	35	22.73
Worms	12	26.67	10	28.57	16	50.00	13	46.43	5	45.45	1	33.33	57	37.01
Fever	41	91.11	33	94.29	23	71.88	20	71.43	8	72.73	2	66.67	127	82.47
Respiratory problem	3	6.67	2	5.71	2	6.25	-	-	-	-	-	-	7	4.55
Diarrhea	14	31.11	12	34.29	7	21.88	5	17.86	4	36.36	-	-	42	27.27
Skin sores	7	15.56	3	8.57	3	9.38	2	7.14	2	18.18	-	-	17	11.04
Stomach aching	12	26.67	9	25.71	2	6.25	4	14.29	1	9.09	1	33.33	29	18.83
Headache	15	33.33	8	22.86	14	43.75	10	35.71	4	36.36	2	66.67	53	34.42
Total	45	100.00	35	100.00	32	100.00	28	100.00	11	100.00	3	100.00	378	245.45

Table 2.3 presents the incidences of illness in the last six months in the households belonging to different land holding categories. The table suggests that as the size of land holding increases, the number of households affected by diseases decreases. However, 72% of the households holding 3.0 to 5.0 ha of agricultural land reported frequent fevers. This may be because of their arduous work in fields.

Table 2.4 presents illnesses reported and visits to health posts during the last year.

Table 2.4: Ill Household members and consultation at Health Post

Caste/ethnicity	HH Member Sick		Health Post Visit					
	Household		People Sick		Household		Times	
	Number	%	Number	Avg.	Number	%	Number	Avg.
Brahmin/Chhetri	22	81.48	36	1.64	21	95.45	70	3.33
Tharu	100	87.71	162	1.62	96	96.00	214	2.23
Untouchable	10	76.92	34	3.40	5	50.00	11	2.20
Terai Dwellers	20	90.90	57	2.85	16	80.00	47	2.94
Others	2	100.00	7	3.50	1	50.00	3	3.00
Total	154	87.47	296	2.60	139	73.89	345	2.74

Table 2.4 presents the distribution of sick household members in the past year and subsequent consultations at heath posts. On an average, 3.50 household members from the Tibeto-Burman group and 3.40 from the Untouchable group were reported sick during the previous year. However, visits to health posts for treatment were found to be more common among Tharu (96%) and Brahmin/Chhetri (95.45%) households. The average visit by sick

household members was relatively higher among Brahmin/Chhetri households. This implies that Brahmin/Chhetris are more aware and conscious of health compared to other ethnic groups in Banigama VDC. The lowest average number of visits by sick household members (2.20) was in untouchable households. This reflects their lower status in Banigama VDC from all the perspectives including exposure to modern health facilities.

The infrequent visits to health post by the Untouchables and Terai dwellers don't mean that they are not afflicted by an assortment of diseases. The members of the higher castes like Brahmin/Chhetris, who are well educated, visited the health post as soon as they felt unwell. In contrast, Untouchables depended more on the traditional healers and quacks. These lower caste people are economically very weak; do not have any qualifications and so have fewer opportunities to use their skills. In addition, they do not consider themselves sick unless they are completely bed ridden.

Higher castes like Brahmin/Chhetri appear to believe that "*Health is Wealth*" and are willing to shell out medical treatment charges, however high. Poor people like the Untouchables prioritize basic needs like food, shelter and clothing, and wouldn't give much thought on spending money on health.

Table 2.5 presents frequency of visits to health post by the households belonging to different income groups. The table would show how the income of a household has a direct bearing upon the health behaviour.

Table 2.5: Distribution of Households Members by their Visits to Health Post and Income (1-year record)

Income level	HH Member Sick		Health Post Visit					
	Household		People Sick		Household		Times	
	Number	%	Number	Avg.	Number	%	Number	Avg.
5 to 10 Thousand	83	87.37	176	2.16	75	90.36	**170**	**2.27**
10 to 15 Thousand	23	82.14	62	2.70	27	117.39	**56**	**2.07**
15 to 20 Thousand	21	84.00	23	1.10	21	100.00	**22**	**1.05**
20 to 25 Thousand	16	94.12	27	1.69	14	87.50	**26**	**1.86**
> 25 Thousand	11	84.62	8	0.73	11	100.00	**8**	**0.73**
Total	**154**	**86.52**	**296**	**1.67**	**148**	**98.65**	**282**	

The incidence of household members afflicted by illness in the past year, their household income level and trend of visiting the health post is presented in Table 2.5. A total of 296 people were recorded as being sick in Banigama in the past one year. On an average 2.70 persons from each Tharu household with income of NRs 10000-15000 per annum got

sick. The table shows that the higher income group (households with incomes exceeding 25 000 per annum) reported the least average sick (0.73). It is also clear that that most visits to village health posts were from the NRs 10 000-15 000, 15 000-20 000, and over NRs 25 000 income group households. The highest average number of visits to village health posts were from the NRs 5 000 to 10 000 (2.27) and NRs 10 000 to 15 000 (2.07) income groups. Interestingly, the average number of visits to the health post from the high-income group (over NRs 25 000 annually) was least at the rate of 0.73 persons per household. Such findings imply that with money being no problem, the high income group prefer contemporary treatment either in the district headquarters or call medical practitioners to their houses. On the other hand, the hope of free treatment draws sick persons of low and lower income group to health posts.

Socio-economic factors and modern rationality are not the only factors that influence the health behaviour of the people. However highly qualified and enlightened the people may be they are not able to disregard cultural traditions completely. Those ignoring social norms run the risk of being isolated from society.

Implications of Illness for Family Peace

There is a close relationship between family income and expenditure, happiness and prosperity and the size of family. A fixed amount of money is spent to fulfil the basic needs of every family. The sources of income determine the amount of family expenditure. The size of family determines the structure and amount of expenditure. Thus, if the size of the family is small, the income and expenditure is balanced and facilitates tension free relations.

In Banigama VDC, many households do not have enough income and are economically very weak. The lack of exposure and awareness subsequently retards their health consciousness. The case studies below would illustrate how illness of a family member can put the whole family in distress and pain.

Case-Study No. 4 (Household no. 73)

Mrs. Kumari Devi Chaudhary, 55, resident of Banigama, ward no. 4 was diagnosed with breast cancer in 2001. Twice, her son and husband took her to Bharatpur (cancer hospital in the central region of Nepal) for chemotherapy. Mrs Chaudhary found the chemo sessions unbearable and vows to never go for the treatments again. She has four members in her household. She did not complain about any pain or discomfort before 2001. Her husband Mr. Ram Bahadur says "We knew of her problem only in 2001".

After chemo, Mrs. Chaudhary has been prone to frequent vomiting and diarrhoea; she has lost hair and says, "I prefer to die rather than go for chemo", indicating the level of pain that she had to bear. The family owns 1.5 bigha (1ha.) of agricultural land and has rented-in an additional 11 Katha (0.14ha.). While they have not sold any property till now, because of her illness, in the Chaudhary family peace has been totally shattered.

Case-Study No. 5 (Household no. 118)

Mrs. Dumi Devi Chaudhary, aged 32, is the wife of Mr. Umesh Chaudhary, 35, a resident of Banigama Ward No. 6. She got married 5 years ago.

In spite of several check-ups in Biratnagar (district headquarters) and Siliguri (Indian border town), they did not have children and feel socially insecure. They have 1 bigha (.75 ha.) of agricultural land. Mr. Umesh is a T.B patient. His wife Mrs. Dumi is suspected to have uterus cancer (diagnosis based on their understanding the medical practitioner's explanation, but yet to be confirmed). Mrs. Dumi has been having health problems for the past five years. She further explains that when she was unmarried, her menstruation was irregular and she used to get stomach pain and was treated by the 'Dhami' (faith healer in their word 'Gurwa'). After they got married, they also consulted 'Dhami'. Both husband and wife are in a measurable psychological condition. They have mentioned that they spent NRs. 70,000/- (Seventy thousand) cash and sold 0.5 ha of land. They believe that their miseries are the result of sorcery.

Case-Study No. 6 (Household no.156)

Mrs. Goma Devi Majhi has been suffering from health complications as a result of treatment/ home delivery assisted by untrained paramedic. Her husband, Mr. Bhim Narayan Majhi's chronic alcoholism is also a constant source of worry.

Mrs. Goma, a 25 year old resident of Banigama Ward No. 9-Dhobiyare has a 8 year old son who goes to school. She got married when she was 15 years of age. She comes from a Chhetri family but got married to a Tharu man. She has continuous pain in her lower abdomen. She explains how it began in the following terms. During the time of delivery eight years ago, a CMA (Community auxiliary medicine man having a training of 18 months; these days such trainings are given by private institutions) was called from Haraich Bazar near Banigama for assisting her delivery. He inserted an instrument (a needle) inside her vagina in the process of examination (in her word needle). She says, "I had unbearable pain. Somehow, I was able to deliver my son. But the pain in my lower abdomen has been persisting since

then. Only last year, I was taken to Biratnagar zonal hospital for check-up". After several attempts, in the hospital she was told that she has developed Tetanus. Now, she fears that she may die. She further explains, "In front of my husband's alcoholic problem my pain/sickness is nothing. He sold some land out of 1ha, which was just adequate for them to feed themselves. "My husband also sold all my sellable ornaments". She asked the researcher in panic, "Brother, tell me, shall I survive amidst such problems?"

Case-Study No. 7 (Household no. 29)

Mr. Jairam Yadav, a resident of Banigama ward no 1, has been sick for the past two years. He is the only earning member in his household and supports six household members with his masonry work. This is a squatter household. Mr. Jairam has no other income sources (like agriculture and other) other than the masonry works. Two years back Mr. Jairam got sick and was diagnosed with tuberculosis. Since then he has been unable to work or earn. Now, one can only imagine how he and his household members are surviving. Tuberculosis remains a major health problem in Nepal despite the fact that highly effective drugs and vaccine now make tuberculosis a preventable and curable disease. In Nepal, the DOTs (Directly Observed Treatment Strategy) strategy has also been recognized as the best cost effective approach to tuberculosis control, yet people like Jairam does not have accessibility to these services.

Case-Study No. 8 (Household no. 31)

Mr. Laxman Sardar, a 32 yrs. old resident of Banigama, ward no.1, has been suffering from an unknown disease for the past two years. The doctor told him that he had bone T.B. He was earning NRs. 3000/- per month in a thread factory, but due to his illness he has been unemployed for the past year. His son and two daughters do not go to school for want of money. He has been advised to go to Farbesgunj, a town in Bihar/India (almost 30 kms South from Banigama), for treatment. In spite of his efforts he could not arrange money to go out for treatment.

Case-Study No. 9 (Household no. 78)

Mr. Tuli Ram Majhi, a resident of ward No. 4 has 3 bigha (2 ha) of agricultural land. He is also a sharecropper of 2 bigha (1.33 ha) of land. He has 6 members in his household. He has been suffering from T.B. for the last 3 years. Biratnagar Hospital advised him to take medicine for 8 months. He completed the course but still complains of persistent chest pain; sometimes blood comes out with his sputum. When it appeared that the medicine couldn't heal his disease, he stopped buying medicine. He said that he had already sold livestock and half of his agricultural land and could not afford more medication.

The above case studies illustrate the measurable conditions of the village families, particularly when the main earning member is out of job for illness. Illness brings further distress to the impoverished families. In case number 5, Mrs Dumi Devi Chaudhary has been directly affected by poor economic condition due to which she had to sell her 0.5 ha of land for treatment. Similarly, case number 7 also illustrates the dire effects of Mr. Jairam's illness on the quality of life of his household members. The condition of Mr Laxman Sardar in case number 8 is tragic; he lost his NRs 3000/- per month job on being diagnosed as having bone T.B. This had forced his three children out of school. Major illness in the family thus can affect the life of the future generation as well.

Most of the households that did seek primary treatment by selling land and livestock could not be cured and had to abandon treatment mid-way. Field observation reveals that Banigama residents feel it pointless to go to hospital, and are unaware of the repercussions of this on health. This has resulted in even minor ailments becoming life threatening. The lack of health perceptions means they were unable to obtain treatment in time to prevent/counter diseases. As a result, while on the one hand they had to sell property, on the other hand they could not be cured and as a consequence had lost faith in modern medicine.

Influence of culture on health and illness

Culture is the way of life of specific society members. Every society has its own culture, norms and values. All over the world, cultural values are seen to affect health behaviour. Even educated people appear to be dictated by the norms of dealing with illness prevalent in their culture. This is because of internalization of values since early childhood.

In Banigama, as elsewhere, the way of life adopted by people consciously/unconsciously in their every day life has a great influence on health and illness. There are certain rituals that mark events from birth to death. With regard to health matters, informal interviews and field observation supports that child rearing in Banigama involves oil

massage. While medically, putting oil inside the ear is not advised, the Banigama inhabitants in general, including the educated, follow this practice. Births, by and large still take place at home with the help of mid-wives and without adequate safety measures. The women assisting deliveries do not have back up-training but rely only on their past experiences. A practice of particular concern is the prevalent method of cutting the umbilical cord with blades. Needless to say, this makes both mothers and babies vulnerable to infections and tetanus.

Many health problems which the people of Banigama suffer from are rooted in the prevailing practices and which could have been prevented with some care. Recalling the processes of both socio-cultural change forwarded by Ogburn - innovation, discovery and diffusion, notably the diffusion of good health practices from the perspective of preventive health such as use of toilets and careful water handling have not been given due consideration. Drinking boiled water is of least priority. The absence of these preventative measures makes diahorrea the leading health problem in Banigama. Locals justify their habit saying: "We have been doing this for years, and nothing has gone wrong". They associate sanitation and health consciousness with urban dwellers. In the event of illness, most people first consult faith/traditional healers. Case no.6 is worth recalling here. The lady Mrs. Goma Devi Majhi suffers as a result of the incompetent home delivery assisted by the inadequately trained traditional healer.

Another problem observed seems to be the *pardah* system (women covering their forehead). The *pardah* system is seen to complicate health problems. Prolonged deprivation of sunlight can sometimes cause pelvic deformity that could lead to death at the time of first childbirth. The prevalence of child marriages in all the Banigama strata meant that childbearing often began at an immature age, with increased risk of maternal mortality as a consequence. The indigenous belief that marriage of a daughter before she menstruates brings 'Punya' and 'Dharma' (blessings) has resulted in generations of child marriages and has also hindered the progress of social and economic development.

From the findings above, it is clear that the relationship between socio-economic characteristics (caste/ethnicity, land holding, housing structure, education and the income etc) and the health status does exist in Banigama.

Several other such cultural practices in existence in Banigama society can be found in the following case studies

Case-Study No. 10 (Household no. 51)

Gita Subedi, 37, resident of Banigama VDC Ward no.3, is a housewife who sometimes goes to work in Jamindar's house. She has five daughters and is pregnant again in the hope of producing a son. Her view on the issue of having a large number of children in quick succession, was that that, she will be unable to reach heaven unless she has a son.

Though physically weak and still breast-feeding, Gita fasts weekly on Tuesdays. She believes that to give birth to son is in the God's hand and so feels she should please the Gods at any cost. This blind faith extends to the fact that she attributes fasting induced acidity stomach pains to witch craft.

Case-Study No. 11 (Household no. 68)

Mr. Dhane Tamang, resident of Ward number 3 of Banigama had migrated from Bhojpur District (hilly Eastern Development Region) 7 years ago. He is 43 years old and earns his livelihood by working as a daily wage labourer at the district headquarters Biratnagar. Two years ago, he probably developed T.B (as he was having mild fever and caugh). Being asked whether he sought the services of any health centre he responded that in spite of visiting a doctor in the medical shop three times he could not be cured. He took the medical shopkeeper as the doctor and believed that he would cure him. He did not feel the necessity of visiting a proper health centre. He continued to work after this and believed that 'Bhagawan' (God) would keep him strong enough to work.

Recalling from the life at his earlier place he said that in Bhojpur their 'Lama' (faith healer and opinion leader) used to help them by curing whenever they fell sick. He went on saying: "In Banigama also Ramjan Tharu treated me by giving 'Mantrieko Pani' (magic spelled water) when I had bleeding from my mouth last year".

He further said, "we go to health post when we get some kinds of injury like fracture in the hand, cuts and accidents. But, we give priority to traditional faith healer, quacks and Dhami and Jhakri if we have problem like stomach pain, fever, headache or any other disease that are not visible.

As can be seen, people in Banigama consult faith healers interchangeably. Tamangs consult Tharu faith healers. Mr. Dhane's problem was of survival rather than that of health and healthy life. Economic status, thus, determines the health status and influences the perception of health and illness.

Case-Study No. 12 (Households no. 96)

Goma Bishowkarma, a 26 year old resident of Banigama VDC Ward no. 4, is a housewife. Her husband is a blacksmith by profession. Goma helps her husband in his work. In the morning and evening, she prepares food for her family members. Besides this, she also goes to work in the field whenever needed.

Goma Bishowkarma appeared in the high school graduation matriculation examinations three times but could not pass and gave up on further study. Although educated she is not free of traditional health practices and traditional belief system.

She does fasting on every Monday, and never misses traditional fasts in festivals such as Teej, Shiva Ratri, Hrishi Panchamee, and other Hindu religious occasions. In justification of her fasting she said that fasting during Teej extends her husband's longevity and fasts on Mondays protect her family from undesirable happenings. She thinks life is a gift of God and healthy life is only possible when the gods and goddesses are pleased.

The above case studies are a few illustrations of how cultural practices and traditional/ religious beliefs influence health behaviour. The cases of Gita Majhi and Goma Bishowkarma illustrate how people continue to depend on God for the cure of ailments when they should have gone for modern treatment. Goma Bishowkarma sees herself as a modern girl but she cannot discard traditional cultural values. She fasts regularly on Mondays and aspires to increase her husband's longevity by fasting on Teej. Generally speaking, fasting is not only done by high-castes like Brahmin/Chhetri and Tharu ethnic group but is also deeply rooted in lower castes and other groups. In the same way, Gita Majhi thinks that she has to please the Gods in order to have a son to ascertain her entry into the Heaven. She does not mind her own health but aspires to have a son at any cost. People of Banigama think that only the sons can offer "Daagbatti" (light the cremation pyre) and dispatch the soul to Heaven. Sons are also viewed as necessary for protection of property and continuity of generations. The same concept is found deeply entrenched in Gita Majhi. A son is overwhelmingly considered a social security in Banigama.

Influence of Education on Health

Education could be a strong determinant of health behaviour and attitudes towards health. Unless people are educated they can not change personal attitudes and remain influenced by traditional approaches to health and illness. When people are educated, they acquire knowledge through different modes which promotes healthy living. The people of Banigama

VDC lack education and health consciousness. Even when attacked with disease, major or minor, people generally do not go to health posts or seek modern treatment but prefer to depend on faith healers, quacks and *Dhami-Jhakris* right from the initial stage.

People can uplift their standard of living with the proper use of the knowledge and skills learned through education. Education is a powerful component and a necessary factor for good quality of life. The educated are expected to find employment and earn through income-generating business. Educated and skilled members of families are able to fulfil basic needs and other necessary desires and promote awareness of healthy habits in their community.

Case-Study No. 13 (Household no. 72)

Mr. Jeet Bahadur Shrestha, aged 39, and a resident of Ward 4 is a Newar (Tibeto-Burman ethnic group) who runs a grocery in Banigama Bazaar. Mr Shrestha has completed his IA (Intermediate) level education from a college. He says that a sense of hygiene is important in order to remain healthy. Likewise, stress free life is a precondition for a healthy life. Elaborating his growing preference for modern treatment patterns he says: "During my father's time, we used to rely completely on traditional healers. We did not mind seeking the help of a traditional healer even if he was from other castes. But now there is a health post in the village and I take any of my sick members of my family to the health post without much delay."

Mr. Shrestha, an educated man with business in the village earns enough for his survival; he can afford modern treatment. His education and regular interaction with all kinds of people have helped broaden his health perceptions. He further added: "I am not a *nastik* (atheist). We have our deities and we worship them. We visit temple regularly and perform all the religious rituals. But, it does not mean that we should stick blindly to traditional norms."

Case Study No. 14 (Household no. 133)

Sumitra Bhattarai, aged 22 and a resident of Ward 7 of Banigama VDC, was educated under the Adult Literacy programe. She was suffering from a peculiar disease that caused her body shake for 10-12 minutes and during this time she would lay unconsciousness and then get well again. Although only momentary, these bouts made her feel miserable and affected her normal life.

Whenever she had a fit, she was given shoes to smell. She was also taken to *Dhami-Jhakri* several times but could not be cured. Everyone told her that she had an evil spirit in her. But one day, she got a book called "Chhare Rog" (epilepsy) where there was a story about a boy who was suffering from epilepsy. She felt that her problem and the boy's problem in the story were very similar. Heartened, she went to Biratnagar hospital at the District Headquarters and began regular medication.

Now, she does not have fits anymore and is completely normal. Her life is changed. She goes for check ups from time to time. Clearly, one could see the connections between literacy and change in attitude to health problem in her life.

Case Study No. 15 (Household no. 161)

Mrs. China Devi Chaudhary, a 26 year old lady from Ward 9, is a high school graduate. She is a housewife and her husband is a school teacher. She has a sewing machine at her home. She works with this machine making clothes, especially women's clothes in the village. She says, "If I work, we can manage the family better." She earns NRs. 3000 per month on an average. She is proud to be able to supplement her family income. She has one eight year old daughter whom she gave birth to in the presence of a trained TBA. She elaborated that they do not want more children and practice the withdrawal method of family planning. She says: "We should nurture our children properly. We should provide better education, clothing and food to our child. So, I don't want any more child." She also made it clear that there is no difference between daughters and sons. In other words, she is not as orthodox as the majority of women in her village. She does not believe in superstitions and spiritual practices in matters relating to health.

The cases above show that people benefit greatly from education. When someone is educated, his/her vision, perception and judgement can change. In case 15 the couple didn't want any more child although they had only one daughter. Sons and daughters were seen as equal and this change in perception could go a long way in removing discriminatory treatment of boys and girls.

We could also see that the lady in case 14 had a change in approach to health as a result of education. Before she read the book on epilepsy 'Chhare Rog' she had a persistent health problem, and was also taken to *Dhamis* and *Jhakris*. After she had read the book she went to the hospital, and was cured.

It can be assumed that the educated are often found to be aware of and ready to follow the proverb "Prevention is better than cure." Educated people are more exposed compared to illiterate people. Education undoubtedly helps people reject cultural prejudices. Because of their exposure and wide knowledge, the educated are able to rationalize their health behaviour and look beyond superstitions.

Land holding and income constitute the basis of determining the class position of different caste/ethnic groups. The upper castes like the Brahmin/Chhetris and Tharus control the larger portion of agricultural land and thus they constitute the upper class of the village society. The other groups like the Tibeto Burmans, Terai dwellers and the Untouchables either have small land holdings that can barely support families or are completely landless. The latter groups constitute the middle and lower classes in the village context. The middle class and lower class are economically backward and are under the strong grip of traditional health culture. Some middle- and lower class people might be health conscious because of their education but due to poor economic condition they cannot take advantage of the facilities offered by modern health system.

When socio-economic conditions are miserable, people's prime concern become mere survival. Preventative actions to promote health and hygiene are unheeded; as a result even necessary things like toilets and fresh water taps are not seen as important. Education makes one realise that when the factors above are not managed, the society will in all probability be the victim of different kinds of ore-faecal diseases.

The government has a peripheral health scheme that extends to Banigama. Banigama VDC has one sub- health post that does not serve the people of Banigama adequately.

Sub-Health Post

The Sub-Health Post at Banigama VDC is located at Banigama Bazaar, in Ward 1. At the time of field-work Mr. Madhab Prasad Regmi was the Auxiliary Health Worker (AHW) and in-charge of the Sub-Health Post. There was altogether four paid staff: one each of Auxiliary Health Worker (AHW), Mother-Child Health Worker (MCHW), Village Health Worker (VHW) and peon. Besides, there were 9 Female Community Health Volunteer (FCHV), one in each ward and 4 Traditional Birth Attendance (TBA) volunteers. The Banigama VDC has constructed a one room building for the health post. This sub-health post gets medicine worth NRs. 25,000 annually. According to Mr. Regmi the major disease registered during this year was skin disease, stomach pain, worm infection, gastritis, pelvic inflammatory disease

(gynaecological) and fever. The out patient department (OPD) registration charge in the health post is NRs 2 and on an average some 15 patients visit the sub-health post daily. The women who visit are mainly there for Depo-Provera injection (family planning devices). According to Mr. Regmi, this sub-health post has immense capacity but is constrained by inadequate medical supplies, exemplified by the annual ration of medicine worth NRs. 25, 000 to operate the health center throughout the year.

Primary Health Post

There is also one Primary Health Center (PHC) at Jhorahat in this constituency, 2 kms from Banigama VDC, and the staff pattern of this PHC is presented below.

Medical Officer	1
AHW/HA	1
Staff Nurse	1
AHW	2
Lab. Technician	1
Asst. Accountant	1
VHW	1
Peon	2
Sweeper	1
Total Staff	**11**

At the time of my fieldwork, the medical officer, lab technician assistant and accountant positions were vacant as the government could not assign staff to these three posts. All the staff available argued that most of the villagers are not even aware of the services available at this PHC. Here, the OPD charge is NRs 3. Patients have to buy all the prescribed medicine. It was also known that medicine worth NRs. 50,000/- arrived at this PHC after or close to their expiry dates. Another concern voiced by the AHW in-charge was that most patients visit the PHC only after consulting faith healers.

A close look at the functioning of these two government health centres would suggest that the infrastructure and services are inadequate and the people are not oriented to make the best use of whatever facilities available at these centres. The inadequacy of health infrastructure and lack of health awareness together sustain a situation where people remain more dependent on the traditional health culture.

The following diagrammatic illustration would present the linkage between socio-economic and cultural factors and the health status of Banigama village.

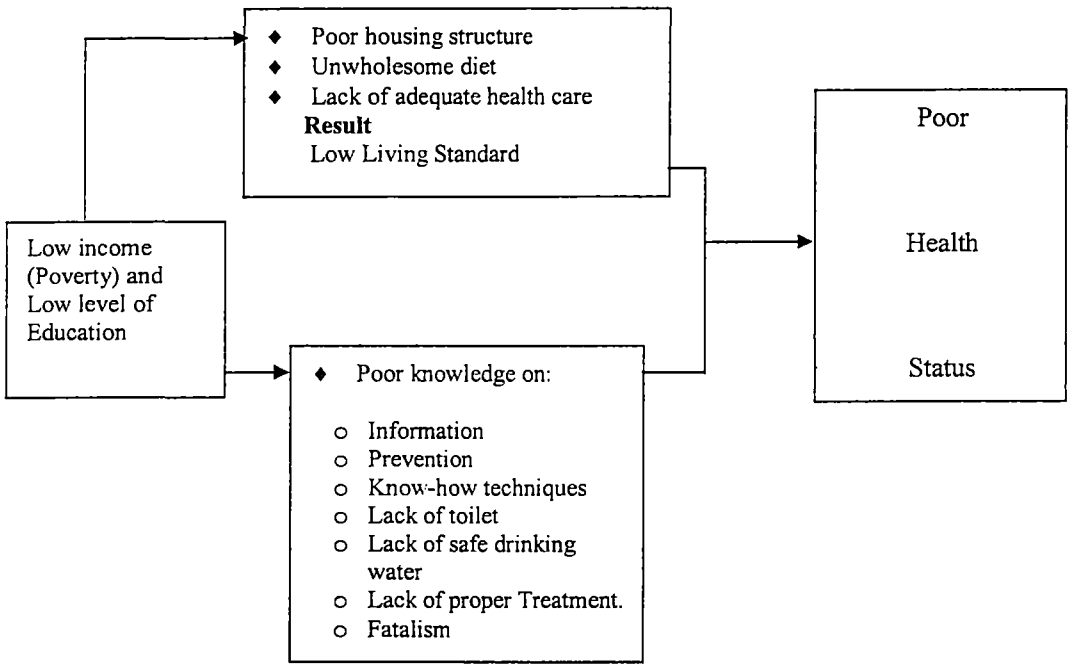

Figure 1: Relationship between socio-economic and cultural factors and their influence on health and illness

The relationship shown in the diagram is rather complex in nature. Findings of this research reveal that by and large Banigama people live in substandard housing, have no access to toilets, are barely literate and receive inadequate health care. As a consequence, it is safe to conclude that these phenomena are affecting the health of Banigama residents directly and impact the social structure in the long run. Naturally, the sick are seen to precipitate downward social mobility, while the healthy succeed in upward social mobility.

Summary

Two groups of people were classified in the study area in terms of socio-economic standing and health awareness. While one group was semi conscious about factors affecting health the other group appeared to be largely unconscious of the preventative and curative aspects of health.

The semi conscious group of Brahmin/Chhetris and some Tharus still thought illnesses are caused by unhealthy behaviour. While these people did seek treatment in health posts and hospitals, they continued to be greatly influenced by traditional beliefs and superstitions. Although they understand that illness is caused by unhealthy behaviour and needs to be treated by physicians, many of the interviewees admitted that they still consult faith healers and quacks and *Dhami/Jhakri* as well.

The group that is unconscious of health issues were largely uneducated and economically poor. This group largely constitutes Terai dwellers and Untouchables; these people believe in various Gods and Goddess and think that healthy life is only possible when the Gods are pleased. When people are seriously ill, they think, "Bhagya ma Yehi Lekheko Thieo" (it is fate). There are yet some people who think that it is because of witchcraft and sorcery that they suffer from ailments. This explains their continued dependence on *Dhami-Jhakria* and inclination to blame any one suspected of being a witch.

Untouchable and Terai dwellers largely think that illness is caused when the Gods are displeased with them; when these people fall ill, they visit temples and promise offerings of hens and goats when they would be cured /recovered.

In Banigama V.D.C., high castes like Brahmins/Chettries are economically and socially better off than other Terai dwellers and Untouchables who are economically deprived and not aware of even basic health habits to build a simple toilet. The economically well off, in contrast, aspire for a long and healthy life. They get their health checked from time to time and seek assorted health related information through different modes. Although there might be a few health conscious people even among the poor, their limited economic condition and education compel them to depend on local remedies.

It is true that everyone is affected by cultural prejudices to some extent. However, those who are economically capable march a step ahead in society. When they get sick they depend less on faith healers and quacks but also seek medical treatment.

As seen in the case studies, injuries like cuts, hand fractures, accidents and other external injuries are taken to health posts but problems like stomach pain, fever, epilepsy and diseases that could not be seen, were taken to *Dhami-Jhakris*. The concept that internal health hazards could be caused by germs or become serious problems warranting medical treatment has not been grasped fully.

Socio-economic conditions have been known to influence human health. For the majority of the people, primarily, their level of socio-economic development determines their health. The social class also appears to affect health. It is observed that people living in poor

economic conditions cannot afford even simple health service, hygienic and balanced diet, proper education, healthy housing, healthy ways of living etc, which may lead to poor health. Thus, poor economic condition or poverty has been recognized as one of the major health problems in Banigama.

From the findings in this chapter it can be drawn that socio-economic and cultural factors have influenced the people of Banigama in terms of change in their perception of health and illness. It has been observed that a move from traditional to modern position has begun but this process of modernisation of health perception and health behaviour is very slow in Banigama.